BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A PRESENTATION AND CRITICAL ANALYSIS OF NATIONAL HEALTH PROGRAMS AND PROPOSALS WITH EMPHASIS ON NATIONAL MENTAL HEALTH PROGRAMS AND PROPOSALS IN THE UNITED STATES

A Thesis

Submitted by

Muriel Zelda Bloch Kolner

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CHAPTER 1

Introduction

A. Purpose

This study was undertaken to ascertain the medical and mental health needs of the people of the United States and to indicate the adequacy with which they are being met. In addition it was also the object of this study to determine the factors involved in meeting those needs.

B. Method

In the presentation and critical analysis of National Health and Mental Health programs and proposals, the writer obtained material from books, periodicals, committee and government reports, laws and statutes, newspaper items and mimeographed reports and pamphlets put out by such organizations as the National Committee for M ental Hygiene, a voluntary organization concerned with the advancement of psychiatric training and research and service to the mentally ill. Thirty organizations sent literature to the writer; these included medical, nursing, hospital, welfare, medical and psychiatric social worker's, mental hygiene, labor and public health associations.

C. SCOPE

Mental health will be taken up in detail; the National Mental Health Act will be discussed as well as voluntary and compulsory health plans, public medical care, the clinic movement, rural medicine, and medical legislative proposals.

Recent developments in the field of national health emphasize the timeliness of this discussion of medical service plans.

In spite of the ambitious title, it is impossible to review in the space available all the medical plans now in operation and the several more which are planning to open their doors. Moreover, information current today would be out of date tomorrow.

The only practical approach, therefore, is to discuss some general features of the various types of medical service plans.

Before proceeding to the plans themselves, however, it will be useful to enumerate some of their significant characteristics, which affect not only their business success but also their social value. Four types of characteristics suggest themselves: coverage, both as to population and services; financing; organization of services; and utilization of services.

CHAPTER II

Medical Programs and Proposals

In order to determine the adequacy with which the programs and proposals meet the medical needs of the people of the United States, we must examine the programs. A rapid inventory of the general types of medical service and health insurance now in operation are:

I. Public Health Activities

II. Group and community systems of medical and hospital service; these plans do not reach the lowest income and indigent groups. The plans consist of non-profit, free-choice, pre-payments hospital plans.

III. Farm Security Administration has undertaken to foster a particular form of community medical organization, financed in part by loans from the administration.

IV. Trade Union Health Activities

- A. Certain national and international unions have set up benefit systems, including temporary and permanent disability benefits.
- B. Medical centers have been established. Members of union medical centers are entitled to medical service at the Health Center for very moderate fees.

V. Cooperative Types of Sickness Insurance

- A. Fraternal Benefit Societies.

B. Employees Mutual Benefit Associations.

1. Self-supporting.

2. Those financed in part by contributions from the employing firm.

VI. Health Insurance through Private Insurance Companies

A. Commercial Disability Insurance.

B. Industrial insurance; this is a term commonly applied to types of insurance that are sold in small amounts, to families in lower income groups, with provisions for payment of the premium weekly, bi-weekly, or monthly.

1. Life insurance, with some limiting provision for total and permanent disability.

2. Life, accident, and sickness insurance.

C. Group Insurance; the essential characteristics are:

1. The fact that a single policy is taken out by the employing firm, covering all or a substantial portion of the employees.

2. The premiums are paid entirely by the employer or the cost is divided in varying proportions between the employee and the employer.

3. If the employees contribute to payment of the premiums, their portion is collected by payroll deductions.

4. Ordinarily, medical examinations are not

required, but both statutes and the rules of the companies require that a substantial percentage of all employees must be enrolled, in order to insure a wide distribution of risks.

The more important of these programs will be discussed in considerable detail; these will be public medical care, the clinic movement, cooperative group medicine, voluntary health agencies, compulsory health insurance, and rural medicine.

A. Public medical care

The term public medical care denotes a special area of community health activities distinguished by two major features: taxation, general or special, is the method by which the funds are obtained; and an agency of governmental--local, state, or Federal--is responsible for the administration of the service.

There is little dispute about the principle of public responsibility for adequate medical care, but there are wide differences of opinion as to the extent to which that principle should be applied and the form of organization that would best serve the purposes to be accomplished.

The advance of public medical care has taken place in four principal directions at different rates of speed. Firstly, a public hospital system, including a large number and great variety of facilities for medical care, has been developed under the auspices of local, state, and federal government. It has grown from three main roots; "the pesthouse,"

the "insane asylums," and the "sick ward" in the workhouse or almshouse. Secondly, various types of clinics have evolved out of the primitive dispensary distributing free drugs to the poor. Thirdly, organized programs, providing for home, office, clinic, hospital, and custodial care at public expense, have been set up for numerous socio-economic groups. They have superceded the old emergency provisions for a tiny segment of the population. And fourthly, separate programs, including complete medical care, have been established for the control of certain diseases and defects. Responsibility for organization and administration of facilities and service for the care of the sick has been transferred from smaller to larger political units. Increasing emphasis has been placed on Federal, state, and state-local, cooperation so as to meet the needs for improvement of public medical care.[1] In 1942 the registered facilities controlled by local, state, and Federal governments provided 1,015,781 beds, or close to three fourths of all beds available in the country.

Tax-supported medical care for persons not indigent has been furnished for a variety of reasons, of which the following have been most evident: because, as in mental disease, only public funds can make the provision necessary for the large number of persons involved; because certain diseases, as tuberculosis, hookworm, and trachoma, frequently involve

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1 Franz Goldman, Public Medical Care, p.2.

or lead to, incapacity for self-support; because only a public authority can provide care in a manner which will protect the rest of the community, as in the case of acute communicable disease; because as in poliomyelitis and some orthopedic conditions among children and in early tuberculosis among young adults, the diseases if untreated, are likely to make permanent dependents of those who, with proper care, could be self-supporting; because, as in eye, ear, throat, and dental defects among children, the education and the usefulness of future citizens are threatened unless these conditions are corrected; because, as with the diseases of babies and of the puerperal state, the widespread public interest in maternity and infancy devolves some responsibility for them upon a public agency; and because, as in the case of syphilis or cancer, the relative costliness of diagnosis or treatment renders many self-supporting persons unable to meet the expense.

Mr. Davis's survey[2] has made it apparent that tax support of medical care should involve governmental supervision but that it does not necessarily imply the governmental administration of these services. Immunization against diphtheria, for example, and other procedures involving the care of individuals may be administered by privately practising physicians paid out of public funds; salaried physicians in the employ of a health or school department; and by physicians who will be paid

2 Michael M. Davis, Public Medical Services, p.118.

by the patient or his family but who must report the disease and the care administered to the public health department, becoming to this extent agents of government in the performance of an accepted public responsibility.

Only through the use of funds gathered over a wider area, such as a state or the nation, can local or regional difficulties be diminished and needed facilities and services be made available in the poor sections. The tradition of the medical profession and the attitude of the American public is that medical facilities and services should be available in proportion to needs, not in proportion to resources. To attain this end, it is often necessary to diminish the differences in available facilities and services among different economic groups within the same community or among different geographical areas.

At present medical costs are met by fees from individuals served, taxation, insurance, and individual or organized charity.

In general, the weakest points observed in public medical services are political influence upon the selection of patients, the appointment of personnel, and the methods of institutional administration; in particular the appointment of physicians poorly selected or poorly trained for the work to be done; inadequate or no professional supervision; and insufficient appropriations. There are examples of public medical services which are substantially free from these faults.

On the other hand, examples of very poor public medical services have been described. Much of the home medical care furnished dependent persons has been of this order; and some governmental hospitals, many prisons, and some public health services have a deservedly poor reputation. There are other examples of private propriety hospitals with lower standards than can readily be found in governmental institutions; of non-governmental clinics which are slovenly and overcrowded; of private philanthropic agencies where nepotism dominates a lay-directed medical service. Every poorly qualified physician who holds a position in public medical service would, if he had not been thus appointed be presumably carrying on private practice and furnishing care to the sick people within the same low limits of his qualifications. The weak spots in public medical service are relative and not absolute.

Quality depends upon the skill of the physician and other professional and technical personnel in diagnosis, treatment, and prevention; the material facilities available; the efficiency of the administrative organization within each service unit; and the degree of coordination among the service units, which, taken together, serve the same patient or the same community.

Probably the most important single factor in maintaining and improving quality of service is professional participation in determining the qualifications and appointment of professional personnel and controlling the procedures through which

professional service is furnished. The general framework for administrative organization of public medical services will necessarily be determined largely by the structure of the governmental unit of which it is a part. Physicians (and other professional groups, such as hospital and public health administrators, dentists, nurses, pharmacists) should have a share in determining the framework of administrative organization of those sections of the government which are concerned with medicine. It is equally important that these professional groups be held by the public authorities primarily responsible for the quality of service rendered.[3]

The principle of government responsibility for provision of adequate general hospitals, that is, receiving a variety of diseases, is undisputed. How far it should be applied is a matter of controversy in a score of countries. The basic issues in question are these: Is establishment of general hospitals a legitimate function, if not a duty of government--just as the provision of schools, highways, sanitation, utilities, recreational facilities, and similar services essential for the welfare of the individual as well as the social organism? Shall facilities built at public expense be operated for the benefit of all who want to use them or only for selected socio-economic groups? If available to everybody, shall general hospitals maintained by public agencies charge self-supporting people for the use of the service at cost or in

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3 Ibid. p. 129.

direct proportion to their ability to pay? Where nongovernment hospitals have developed, shall they be supervised by the state? Shall they be utilized and paid by public agencies for service to designated groups?

With the growth of public general hospitals a new and crucial problem has arisen: Who shall be admitted to a government facility?

One school of thought advances the idea that a hospital built at the expense of the taxpayer should be operated for the benefit of all who want its services; it should accept paying patients as well as those who could pay only part of their charges or nothing. There should be no class medicine. It would be incompatible with democratic ideals to maintain one set of hospitals exclusively for the poor and another for persons with resources of their own. Public hospitals accessible, attractive, and worthwhile to all would receive substantial income from paying patients, with the result that the deficit to be met by taxation would be reduced. They would effectively demonstrate the good use that can be made of tax funds and hereby stimulate community interest in demanding and supporting adequate health services in general.

This reasoning is sharply contested by a second school of thought holding that public hospitals should admit only persons unable to afford care in private hospitals, if not solely "public charges." Strictly observed, they believe, should be the principle of charity so admirably expressed in

the words: "None may enter who can pay--no one can pay who enters", and patients with resources of their own should be referred to nongovernmental hospitals. The entrance of government into this field would not be conducive to sound public policy, they say, as it would make unfair competition for the hard-pressed voluntary hospital and, in the long run, deal a mortal blow to such institutions.[4]

Failure to initiate a nationwide hospital policy based on the principle of Federal-State cooperation has resulted in the serious lack of adequate facilities in many parts of the country and in the perpetuation of needless and wasteful rivalry between governmental and nongovernmental hospitals.

The increase and expansion of public facilities for the care of the sick in the United States has taken place without over-all planning. The result is that two major shortcomings have come to the fore. Hospital beds both general and special, are very unevenly distributed. They are relatively numerous in wealthy areas and rare in poor sections of the country. Furthermore, governmental and nongovernmental activities in the hospital field are uncoordinated. They duplicate in some communities and are lacking in others. These facts clearly prove the need for a hospital policy devised, accepted, and carried out by all groups concerned.[5]

The evil of utterly uneven distribution of health

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4 Op.cit. p. 38-39.
5 Ibid, pp. 41-42.

personnel, with wealthy sections and urban areas oversupplied and poorer sections and rural areas sadly undersupplied, is not incurable. What is necessary according to Franz Goldman to remedy this situation is the determination to apply principles of action that have already proved their value, such as: construction of good medical care facilities where needed, in particular in rural areas; organization of payment for health service so that professional persons are assured of a satisfactory income whether they practice in a metropolis or in a small town; establishment of central registers primarily for physicians and dentists which list vacant practices as well as localities desiring a physician or dentist and submitting necessary information including evidence of need; limitation of the number of patients a physician or dentist may accept under a designated program; financial assistance to professional persons willing to move to a locality with established need; and scholarships for students of medicine, dentistry, nursing, and social work who later will stay a stated number of years in a rural area.

The opponents of a general system of public medical care stress two major facts that mitigate against its adoption. Much of the burden of financing the service would be placed on those who have considerable income and property. New and heavy levies on the minority of the population might well defeat their own purpose by forcing liquidation of assets to pay taxes.

For what purpose and how far should the method of taxation be employed? According to Franz Goldman,[6] taxation should be used primarily for the building and development of adequate medical facilities, whenever there is proven need for them and other resources are lacking. If a well-organized program of medical care is established or planned, no valid reason exists for public agencies to be reluctant in spending tax funds also on nongovernmental buildings serving community purposes. Insurance funds ordinarily should not be utilized for capital expenditures. Special conditions, such as those prevailing in large industrial plants, may justify exceptions to this rule. Such policy follows from the assumption that medical care facilities should be established and operated for all rather than the selected groups who contribute to the insurance scheme.

Among the groups eligible for public medical care, apart from members of the armed forces, are veterans, merchants, seamen, Indians and Eskimos, and certain groups of persons in the service of Federal agencies. They are in a class by themselves. With minor exceptions they are self-supporting; they are entitled to obtain all the care they need and are automatically eligible for service if they belong to one of the groups.

The fundamental issue at stake is to help as many people as possible not to become dependent because of serious illness

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6 Ibid. p. 188.

or defect rather than providing for them only after they have exhausted their last resources and lost their economic independence.

This trend is well exemplified by the development of public medical care for the more effective control of venereal diseases. In years of relatively normal incidence of communicable disease the reported cases of syphilis and gonorrhea led the list of all notifiable diseases in the United States. Their frequency, their impact on the individual and family life, and their socio-economic importance to the nation have brought about a movement to eliminate one of the most formidable obstacles to adequate treatment, namely the prohibitive costs. Following efforts on a small scale, a nation-wide program aided by the allocation of Federal funds to the states, was inaugurated in 1938. It rests on three major tenets: free diagnosis and treatment facilities for specified groups of people; free distribution of anti-syphilitic drugs on the request of any physician for the treatment of his patients; and the availability of service irrespective of the place of residence of the infected person. They accept all persons who apply for diagnosis and emergency treatment; those referred by a private physician for consultation or continued treatment; and those unable to afford private medical care.

Besides patients with communicable diseases, those with physical handicaps receive special attention in the United States. A nation-wide program of medical care for crippled

children was developed through special services in the Social Security Act of 1935 and its amendments and rapidly extended by means of Federal-State cooperation. Similar principles are embodied in the 1943 Amendments to the Vocational Rehabilitation Act providing medical care for disabled civilian adults through a Federal-state program.

In some parts of the country determined efforts have been made to purify the atmosphere of the poor-law, so offensive to applicants of medical care. On the whole, progress has been slow. Residence and settlement requirements, inadequate eligibility standards, legal family responsibility, administrative practices subjecting applicants to indignity, and local responsibility for care have continued to dominate the scene and retard the development of adequate programs of public medical care.

Leaning on the experience accumulated in a number of progressive communities, the American Public Welfare Association has taken the initiative and leadership in advancing the organization and administration of adequate medical care for persons who cannot provide it through their own resources. In 1939 this organization states the "Essentials of Tax-Supported Medical Service" to be as follows:

1. Scope and amount of care sufficient to include all necessary preventive and curative service required by persons unable to procure it for themselves.
2. Good quality of service and of personal attention.
3. Reasonable accessibility and promptness of service.
4. Continuous care of the patient including:
   a. Continuity of diagnosis and treatment of different types of service--home ambulatory, and hospital;

b. Continuity of preventive and curative service;
c. Integration of medical and social treatment.

5. Reasonable payment to all participating medical practitioners and agencies.

6. Participation of medical profession and agencies in planning service; and as wide a participation in furnishing service as is compatible with quality, scope, and economy.

7. Economy of expenditure, consistent with adequate scope, amount and quality of service.

8. Provision of service under conditions which will encourage its full use; avoidance of conditions which will deter the needy from securing necessary medical care or discourage well-qualified practitioners or agencies from participating in the service. Adequate records of professional service and expenditure.[7]

The methods of paying physicians other than those who are employed full-time are so diverse that only broad statements can be made. Physicians appointed on a part-time basis receive a fixed salary, usually per month, with or without allowances for transportation depending upon the type of work. In rare instances, they are paid a flat fee per eligible person per call.

Under the organized panel system public agencies and physicians conclude a more or less formal agreement as to the method of payment, the fees, and the administrative procedure for the control of expenditures, thus substituting collective bargaining for individual understandings. The principle of authorization of service is generally applied.

Where a fee-for-service system is chosen, the physicians are compensated for medical attention and transportation in proportion to the amount of authorized work actually done and

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7 Ibid. p. 84.

on the basis of a special fee schedule adapted to local conditions. As a rule the fees are set below those ordinarily charged in view of the fact that reimbursement is certain while collections in private practice usually represent only a proportion of the charges.

Often the discount is graded according to the type of service performed. Some communities allow the participating physicians a flat rate according to the number of people eligible for service at a given time or the number of sickness cases actually attended, regardless of the amount of service given in the individual case.

Not infrequently a fixed amount of money per month or year is paid into a pool and distributed, or prorated if necessary, among the physicians in proportion to the service actually rendered.

Often different methods are used in combination. Agreed fees are paid to specialists for approved service and flat rates to general practitioners for the work covered by an agreement.

The free-choice system makes it possible for the needy patients to obtain, without discrimination, the services of any of the physicians participating in the local program; to remain under the general care of the same doctor regardless of the vicissitudes of life; and to change the physician within certain geographic, time, or other limits. It relieves the sick from the strain of traveling to some distant point for

service. Because of its competitive aspects, it promises ready response to call and eagerness on the part of physicians to give their best. The doctor is offered an opportunity to render service to the needy and to receive payment for it. He can establish new relationships with patients hitherto not seen at all or attended irregularly. He can reinforce the bond of sympathy and interest between himself and his old patients. To the public agency the free-choice system is attractive because it is certain of ready acceptance by the medical profession.

On the debit side of the ledger are numerous more or less unavoidable weaknesses in the free-choice system. Many patients choose and change the physician on condition that have little or nothing to do with professional experience and skill. They drift to the "busy doctor" recommended by a close associate, the neighbor, drug store clerk, barber or beautician, or to the one most ready to meet all their requests. Not all physicians in active practice in a locality care to participate in the program. Often the names of the best trained and most experienced practitioners, particularly specialists, are conspicuously missing on the official list of physicians available for home and office care. Yet these very physicians serve the needy in the hospital wards and clinics where there is no free choice.

The combination of the free-choice panel system with the free-for-service method rather than the capitation system of

payment multiplies and intensifies its shortcomings. To control the expenditures and prevent excessive use, if not abuse, of the service by both patients and physicians, a host of rules and regulations must be worked out and enforced. The patient has to obtain authorization to seek medical attention at public expense. This may involve several money-and-time-consuming trips to the welfare office. The physician must plan his services according to the more or less voluminous "Book of Rules" describing the types of services and the fees allowed. To obtain payment he must apply for an "order" for each case of illness to be treated, for the care to be provided, and for the type, amount, and period of service he wants to give. He has to fill out form after form for authorization and send in itemized bills which often have to be notarized. The compensation he finally receives often seems to him disproportionate to the demands on his professional skill and the effort spent on form filling, book-keeping and accounting. The public agency which wants to compensate the physician according to the amount of service actually rendered must employ professional and clerical personnel for the approving of service; the reviewing, auditing, and certifying of each bill submitted; the regular payment of accounts; and the professional supervision of the quality of the physician's work. This means that cumbersome, complicated, and costly administrative machinery has to be maintained. Even if a special fee schedule is agreed upon, the free choice system

is more expensive and harder to budget than others.

Under the part-time or full-time district physician system the needy sick are provided with care in the home and occasionally with service at the clinic or office of the physician. The physician can render the services deemed necessary without applying for authorization and submitting itemized bills. He can count on an income that is certain and not reduced by expenses for over-head. The public agency can establish definite qualifications for the employment of physicians, set standards of service, organize the cooperation of general practitioners and specialists, administer the plan easily and inexpensively, and rely on the counsel of professional men familiar with the socio-economic conditions in the various districts. It may find the system comparatively economical. On the other hand, the district physician system implies that the patient cannot choose his doctor.

Those interested in the job may be very young physicians looking for a springboard into private practice and quitting as soon as they are settled; old physicians ready to retire but anxious to retain a source of income; men who have been a failure in private practice; "bootlicker", or "favorite sons" of politicians.

The number of district physicians may be insufficient to meet the normal needs, including emergency and night calls, and entirely inadequate to cope with the occasional heavy demand for service.

If full-time salaried physicians are employed to attend the needy at the home, clinic, and hospital the patient can expect complete, continuous, and consistent service. The physician receives an income that is fair, predictable and certain. Freed from the necessity of chasing after the elusive dollar in private practice, he can spend all his time and energy on his job. The public agency can easily integrate and administer all services for persons eligible for public medical care. Moreover it can assign full-time physicians to take charge of certain preventive health services in addition to the care of the needy sick and thereby simplify and improve its total program.

The unavoidable disadvantages of this method of organization are basically the same as those of the district physician system. The arguments advanced against it rest on evidence of many unsound administrative procedures in organizing and staffing the service; on the premise that a monthly salary check would "kill all incentive" to be interested in the patient; and on the fear that large scale "socialization of the profession" inevitably would follow successful experience with a miniature program.

In a clinic worthy of the name those needy sick who are not bedridden can obtain thorough and competent diagnosis and treatment, both medical and social. There are readily available the services of physicians, specialists as well as general practitioners, and of nurses, medical social workers, and

technical personnel; equipment for diagnostic and therapeutic procedures; and an administrative machinery geared to the needs of persons with small or no means. The physician has the essential resources in material and personnel at his disposal for full and prompt use. He is stimulated and benefited through steady and close contact with other colleagues and especially the various specialists and consultants; relieved from certain routine functions and clerical work; enabled to attend a considerable number of patients in a convenient way; and provided with an opportunity to gain experience, do research work, and participate in teaching. From the community point of view the clinic system serves to offer a wide range of specialized services; foster quality of care; keep the costs of the service relatively low by full utilization of available personnel and equipment; provide for health education in combination with care of the sick; and integrate medical care and social work.

The basic objection to clinics as they are operated now is that patients have to go there rather than to physicians in private practice if and as long as they are in need, but are not accepted and advised to seek private physicians' service when they are earning a modest living. This policy causes dissatisfaction among the sick who are shifted around as their income changes; bitterness among the physicians who lose old and can hardly gain new patients; and gaps in the service for the sick, as neither continuity nor completeness

of care are assured. Besides, sins of commission and omission in organizing clinic service have furnished much material for opposition to the system as such. The institution may be overcrowded and understaffed, with the result that the patients confused and anxious, have to wait for hours in inadequate rooms only to get "rush medicine." The staff may consist of young doctors, internes and medical students--all working without the supervision of experienced men. It may change so often that the patient sees a different doctor on each visit. Highly qualified physicians giving a certain part of their time to work at treatment clinics may be late or irregular at the sessions since they cannot help putting private practice before a service expected to be donated. The sick individual may be shuttled from one clinic division to another or from one clinic to several others without receiving integrated treatment.

B. Clinic Movement

The clinic movement in the United States has advanced without being part of a broad health program. The failure to organize physicians' service and to place the clinic in an integrated system of preventive services and care for the sick has caused an unending stream of controversies over the relationship between clinics and physicians in private practice.

The practicing physician who depends upon fees for his livelihood must, by force of circumstances, insist that the

clinic not interfere with private practice. Inevitably, any member of a health profession who has to struggle in competitive practice will closely scrutinize the clinic's work as to the features carrying dangerous potentialities. The clinic in turn must respect the legitimate interests of the health professions. It has no choice but to draw some dividing line, artificial as it may be, between its areas of activity and the "territory" of the private physician.

Clinics may be divided into two broad categories: those which have been initiated and developed as nonprofit institutions under the auspices of public agencies and voluntary organizations, and those which have been set up by groups of physicians for the purpose of practicing medicine ("private group clinics").

The nonprofit clinics are of two basically different types. One set is organized primarily to provide treatment for the ambulatory sick belonging to certain economic groups, and a second set is organized primarily to preserve and promote the health of apparently well persons by providing for diagnostic services, health education, and health supervision. In neither case is the distinction between treatment and preventive services fully maintained. Exceptions to the rules are made in a few health activities where the need for integration has been felt most. In contrast, the group clinics maintained by physicians in private practice are organized to offer service without distinction as to type. The need of the

patient and his ability to pay are the principle factors determining the scope of care supplied.

The differences in the general objectives of the various types of clinics are reflected in the policies and procedures governing admission. The great majority of the treatment clinics are maintained for recipients of public assistance, general and special, and, to a varying degree, also for people who cannot afford such service at private rates. A relatively small number are operated for the benefit of other selected groups, such as industrial workers and university students. A few are designed for service to the whole community. Clinics of the preventive type are open either to anyone who wants to use them or to persons below a certain income level. The services of private group clinics are available to the public at large regardless of income, although in actual operation self-supporting people above the low-income level constitute the majority of all patients treated.

C. Voluntary Health Agencies

As defined by Gunn,[8] a voluntary health agency is an organization that is administered by an autonomous board which holds meetings, collects funds for its support chiefly from private sources, and expends money, whether with or without paid workers in conducting a program directed primarily to furthering public health by providing health services or health education, or by advancing research or legislation

8 Selskar Gunn and Philip Platt, Voluntary Health Agencies, 1945.

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B. Dunning, Dunn and Hanly Plath, Principles of Community
Medicine, 1949.

related to health, or by a combination of these activities.

The voluntary health agencies have substantially advanced public health by carrying out experimental projects and this often paves the way for official agencies to take over such programs.

Voluntary health agencies are in a position to supplement Public Health Department activities; they can take up new technical procedures more rapidly than official agencies which generally operate under both statutory and financial restrictions. Private agencies assist by lending personnel or by contributing funds for special equipment, supplies, or services. However, there are limitations to such assistance due often to reservations on both sides. Sometimes a health department official does not want the program or he does not want to be beholden to a private agency. There may be feeling that in accepting voluntary help he may be surrendering some portion of his independence in action. On the other hand, the voluntary agency may be uncertain about real intentions of officials.

If we can conceive all technical service for public health eventually being taken over by public agencies, there would remain two functions for a voluntary public health agency. The voluntary public health agency would remain a guardian of the official health agency; it would be composed of alert informed citizens, sensitive to community's need in public health, ready to defend, strengthen, criticize, support

or assist official agency, as a servant of the public, in carrying on broader programs with better quality of work; and the voluntary agency would stimulate and finance research.

The idea of cooperative group medicine has not yet penetrated to the general practice of medicine. Indeed it is constantly being thwarted by the present economic set-up of medical practice. The patient pays a separate fee for each service rendered, and the doctor is compelled to send the patient from one specialist or one laboratory to another in order to obtain the data that he needs to reach a diagnosis or carry out treatment. The costs rapidly mount, so that often needed special examinations are postponed or omitted because the patient cannot afford to pay for them. Moreover it is to the practitioner's interest to minimize the number of these special examinations because that will make less money available for the payment of his own bill. Medical care still centers around the individual practitioner who is a private entrepreneur, and who singlehanded, to the best of his ability, provides medical care for those who seek him out, and who at the same time is compelled to make a living from these activities.

The proposals for improvement of medical care have concerned themselves principally with application of the insurance principle to the payment for medical care. Sickness insurance is set up to spread the cost of illness. Application of the insurance method makes it possible to meet the extraordinary costs of major illnesses out of a common fund to

which all contribute.

Experience has shown that a certain small percentage of both patients and doctors take advantage of the insurance fund if payment is made for each service rendered, instead of by straight salary, and run up unnecessary bills. So in order to protect the insurance funds, plans employing the fee-for-service method of payment compel the patient to pay for the first few calls of any illness, and set up a complicated and expensive system of checks to detect cheating. Such safeguards discourage the patient from calling the doctor at the first signs of illness, and impede preventive services, but are essential to protecting the insurance fund from bankruptcy. A number of insurance plans initiated by medical societies suffered such financial losses, were compelled to give up complete medical coverage and now sell only indemnity insurance for surgical operations. Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained.

D. Compulsory Health Insurance

Compulsory health insurance, briefly, is a system by which medical and hospital care would be available to all who desire it, the cost being paid by employers, employees and, possibly, government. Compulsion would stem from the fact that everybody would be required to pay taxes regardless of whether or not he sought medical care. Cash sickness benefits refers to a system by which those covered would be

entitled to weekly benefit payments in case of illness. The purpose is to make up partly for loss in wages or salaries during such time. A comprehensive system may offer both medical and hospital care as well as cash benefits, and there have been a few such proposals.

Behind the demand for compulsory systems of medical and hospital care or cash benefits, or both, is the belief that present medical treatment is inadequate; that this results in large losses that could be prevented; that an economic barrier exists between the needs of the average patient and the medical services available.

According to Ernest P. Boas,[9] national compulsory health insurance is the only practical method of spreading the benefits of good medical care to the whole population. People can budget and make regular payments when they are well that will pay for medical services when they are ill. Such insurance would be financed by payments from all workers, with equal payments from their employers, supplemented by funds from general taxation. Contributions would be collected by payroll deductions, like other social security payments. Only by supplementing the workers' contributions by contributions from their employers and from taxation can sufficient funds be raised to finance a satisfactory medical care program. Since payroll deductions are calculated at a certain per cent of

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9 Ernest P. Boas, "Why Do We Need National Health Insurance?", Reprinted from Ethical Frontiers by permission of the New York S ociety for Ethical Culture, pp.14-15.

the worker's wages, those with smaller incomes would pay less than those with larger incomes. It is estimated that a deduction of three per cent of wages up to the first $3600 of income would provide sufficient funds. One-half of this would be paid by the worker, one-half by the employer. Thus a man earning $500 a year would pay $17.50 for one year's coverage for himself and family, whereas one earning $3600 would pay $54.00; their employers would pay equal amounts. Yet both families would receive the same complete medical care.

There are definite advantages in financing a national health program by contributory insurance payments through payroll deductions under the social security laws. It is just and psychologically sound for the worker to contribute to the costs of his own medical care. Knowing that he has paid for medical service, he will regard this service as a right, he will demand that it be adequate; and every stigma of charity, that in the past has been associated with medical services provided by government, will be eliminated.

Tax funds will have to be provided in addition to the social security payments. Medical care of the indigent, who are not covered by virtue of employment, should also be included in a national health program. Additional funds are needed for the construction of hospitals and health centers, especially in rural areas, for the extension of full-time public health departments, for research, and for medical and other professional education. Without the leaven of teaching

and scientific investigation no national health plan will develop the highest type of medical care.

The total sum of money that would be collected for medical care under such an insurance program under the social security system would amount to between four and five billion dollars a year. This is a huge sum, but we must recognize that this will not all be new money that has to be raised over and above present expenditures. Before the war, total expenditures for medical services in the United States was about four billion dollars, which represents about four per cent of total consumer income. The sum collected by the national insurance fund would take the place of the four billion dollars now spent largely by private individuals, in widely varying amounts.

The application of the national compulsory health insurance principle will solve the economic problem involved in the provision of medical care to all, but it would be a grave mistake to believe that all problems of medical care will be solved when the economic basis alone is assured. Professional and technical considerations determine the adequacy of medical care, whether paid for by an insurance fund, by governmental, philanthropic or private enterprise. The record of the various compulsory health insurance schemes in Europe demonstrates that an economic solution alone is not the whole answer.

We must adopt a fresh approach to the technical and professional aspects of medical care, just as we have for the economic aspects. The old answer was to supply a family physi-

cian for all. This would give each patient the services of a general practitioner and assure the doctor's income. It does not allow for all of the components of medical care that today are accepted as essential; it does not recognize the preventive services, the services of specialists and consultants, the provision of the more complex diagnostic and therapeutic facilities, and hospitalization. Medical machinery must be geared to carry to each patient the full benefits of the whole art and science of medicine. What is needed is a better coordination and organization of medical facilities. A health insurance scheme must be based consequently on the principle of cooperative group practice.

Group practice offers many advantages to doctor and patient. It cuts down overhead expense, - rent, secretarial and nursing help - it eliminates duplication of expensive laboratory equipment, and m akes it possible to use such equipment to capacity. This saving can be passed on to the patient who can thus obtain the best diagnostic and therapeutic services for at least thirty per cent less than if he had to visit many individual doctor's offices, each one fully equipped but utilized only part of the day. But there is a much greater merit to the plan. When a group of doctors work together, examine the same patients, and discuss the many problems that arise in the daily practice of medicine, they are constantly teaching and stimulating one another. Each physician is learning something daily from his colleagues, and is ever stimulated to his

best performance. If such group practice is made available by means of a prepayment plan, whereby the patient is entitled to all of the facilities of the clinic that are needed in his particular case, without having to pay separately for each item, it makes possible much better medicine. No longer will the doctor who suspects that the patient may have a stomach ulcer ask whether he can afford to have X-rays taken. He will order them freely when indicated, without fear of reproach should the X-rays prove to be negative.

Such group practice should be concentrated in health centers and hospitals. As we have seen, in many communities throughout the country such facilities are lacking, yet no group of physicians can do satisfactory work without them. To bring good medical care to the country at large and to provide for the needed extension of public health and preventive services fully equipped health centers, smaller general hospitals and large general hospitals must be established throughout the country. Health centers will be the units in which the preventive medicine of the local community will be established. They should be large enough to include facilities for offices for physicians of that area, who with proper equipment and working as a group can take care of many of the local needs. These health centers should be integrated with county or district hospitals, and these hospitals in turn should be related to larger hospitals in the urban centers where the most difficult cases and those requiring the most specialized treatment

will be taken care of. Very many communities have not the financial resources to establish such institutions, and Federal funds will have to be made available for their construction.

E. Rural Medicine

Widespread rural areas are very poorly served by hospital facilities. Over 1,250 of the 3,070 counties in our Nation are without a single satisfactory general hospital. Over 700 of these counties have populations exceeding 10,000 people.

How many "queer" folks in rural communities are cases of untreated mental disorder is anybody's guess. The fact is that these people are seen about the villages or found hidden away in their homes, mainly because there are not enough modern mental hospital beds in which to care for them or mental hygiene clinics in which to treat them. Authorities claim five beds per 1,000 persons ought to be supplied to care for cases of mental disorder, but the predominantly rural States have only 3.4 beds per 1,000 compared with 5.6 beds per 1,000 in the most Urban States. The hospitals for convalescent care or for treating special conditions found in the cities are practically never found in rural sections.

In order to stop disease before it starts, it is necessary to have strong and effective organization of public health work. Such a program should and can promote good sanitation, farm safety, the prevention and control of acute communicable diseases or venereal infection or tuberculosis, the care of expectant mothers and of infants, the protection of children

in and out of school, the improvement of nutrition, the education of all people about healthful living.

Yet in 1941 almost 1400 of America's 3,070 counties were without the services of a full-time department of public health and practically all of these were rural counties. War conditions made the situation even worse.

F. Legislative Actions

1. The Capper Bill

The Capper Bill was introduced by Senator Capper of Kansas, in January, 1941. Like the Wagner Bill, it provides for the establishment of state systems of disability insurance, with substantial federal subsidies, subject to the approval of the Social Security Board. It goes much farther than the Wagner Bill, however, in prescribing the essential features of approved state systems.

The act provides that state systems must include a schedule of premium payments "equal at least to the following weekly rates:"

Weekly Premium Schedule

When a wage employee's weekly wage rate is	The employer's premium shall be	The employee's premium shall be	The State's premium shall be
I. Under $15.00.....	$0.40	$0.10	$0.60
II. $15.00 to $19.99...	.40	.20	.50
III. $20.00 to $24.99...	.40	.30	.45
IV. $25.00 and over....	.40	.40	.40

Weekly cash benefits are to be paid at rates varying from six dollars to sixteen dollars according to wage classification and number of dependents. Cash benefits are payable for "twen-

ty-six cumulated weeks" in any year. Maternity benefits are to be provided for at least six weeks prior to delivery and six weeks subsequently. The periods of maternity benefits are to be in addition to the twenty-six weeks allowable for disability.

In addition to cash benefits, medical services are to be provided, consisting of the services of a general practitioner--at the office, house, or hospital, the services of surgeons and specialists, hospital services--including x-ray examinations, laboratories, and clinics, dental service, and the service of nurses outside the hospital. The period of medical service may be limited to III days in connection with any one illness or injury and is subject to further limitation under special provisions.

The act does not apply to agricultural labor or to domestic service in the case of an employer having less than three employees.

Otherwise it applies to all wage and salaried workers "except for any person employed under an express contract for a term of not less than one year at total wages for a year in excess of $1,500, and except any person employed at non-manual work receiving wages in excess of $30.00 a week". The bill provides for voluntary insurance, under specified conditions, for certain groups not subject to the compulsory features of the proposed statute.

The Capper Bill differs from the Wagner Bill in that it provides much more liberal Federal subsidies; it involves much

more detailed prescription by the Federal Government with regard to the terms and features of the state systems, and it sets up a highly localized but complicated system of administration, including the State Commissioner of Health, State Commissioner of Health Insurance, a State Appeal Board, Local Councils, Local Finance Managers, Local Medical Managers, Local Public Health Officers, eleven to fifteen State Board members appointed by the Governor, four appointed members in each local area, and an indefinite number of Local Advisory Committees in these various local areas.

The Wagner and Capper Bills, providing for state systems of health insurance, do not specify the form of financing, but it was anticipated that states adopting such systems would rely chiefly on payroll taxation. The Eliot Bill provided for financing the proposed health insurance system through payroll taxes.

2. The Wagner-Murray-Dingell National Health Act of 1945

The Wagner-Murray-Dingell National Health Act of 1945 was introduced in both Houses of Congress, November 19,1946; this was the third revision. The original bill added health insurance to the Social Security system; national health insurance was but one of several provisions of this bill. Other provisions, such as extension of Social Seciruty, the nationalization of unemployment compensation, and federal aid for general relief, are beyond the scope of this discussion.

The bill provided that health insurance would be estab-

lished by the creation of a national medical care and hospitalization fund, to which employers and employees would each contribute 1.5 per cent of the first $3,000 of annual wages, making 3 per cent in all. Self-employed would contribute the entire 3 per cent themselves. Contributions amounting to an additional 4.5 per cent of wages would be made by employers and employees, 9 per cent in all, to pay for the other benefits of the bill. Two of these latter provisions have an important bearing on health, namely, those providing for cash payments during temporary and permanent disability.

For every insured person and his family, the medical care and hospitalization fund would pay for unlimited doctors' care including specialists, for hospitalization up to thirty days, x-rays, and laboratory tests. Dental care, nursing, medicines and drugs would not be paid for.

Patients would be free to choose their physicians from among those participating in the program, whether engaged in individual or group practice. Standards of competence for specialists and hospitals would be established by the Surgeon General of the United States Public Health Service. Any licensed physician could participate in the program as a general practitioner.

The national fund would pay physicians for the services rendered to patients covered by the system throughout any of the several methods--fee-for-service, capitation, part-time or full-time salaries, or by a combination of these methods. The

physicians of each area would choose by majority vote the method of payment to be adopted in that area. Hospitals would be paid up to $6.00 per day for each day of care they furnished.

The 1943 Wagner-Murray-Dingell Bill never came to a vote in Congress. Nevertheless it caused a storm of comment. Enthusiastically backed by organized labor and some farm organizations, it was considered by them "so enormous an improvement over our present social security provisions that no responsible person, deeply concerned with the welfare of our country, can fail to support it."

At the same time, it was vigorously opposed by representatives of organized physicians, in whose minds it was "socialized medicine." The opposition groups said that the bill implied that sick people would have to depend on a doctor paid by the government to work only eight hours daily--emergency cases would have to wait until the doctor checked in. Patients would have to go to the doctor assigned to them by political bureaucrats, and doctors would become incompetent because methods and remedies would be fixed by bureaucratic superiors. Largely to oppose this bill, physicians and drug houses raised and spent over a quarter of a million dollars in giving out "information" of this nature. Extremes were reached with statements like, "It is doubtful if even Nazidom confers on its gauleiters the powers which this measure would confer on the Surgeon-General of the United States Public Health Service."

One group of physicians attempted to promote a national movement to boycott any legislative program such as the Wagner-Murray-Dingell Bill, giving physicians this advice: "If such legislation as the Wagner-Murray-Dingell Bill passes and your patients come to you for services under the plan, tell them you don't serve the politicians, you serve them. If they want to know what they are going to get for the money deducted from their pay checks for health insurance, you don't know."

It is of course debatable whether an insurance scheme such as that proposed in the bill would in fact have the disastrous effects predicted by its opponents. Certainly the bill itself had no provisions for assigning patients to doctors, for regulating physicians' hours of work, income, or the methods of practice, except for the elementary requirement that specialists meet national standards of competence in their particular fields.

Many persons in favor of federal legislation for health and medical care felt, however, that the first Wagner-Murray-Dingell Bill fell far short of providing a truly adequate health program for the nation. They pointed out that it included, for example, no provisions for the construction of any hospitals and health centers. It contained nothing to encourage the expansion of preventive health services. It offered nothing to induce physicians to modernize their methods of practice by joining together in groups instead of continuing in the traditional solo practice of the old-time family phy-

sician.

Some felt, too, that the whole population should be protected under the plan, rather than merely employed persons and their families. For this reason, and to promote preventive health services, support from general taxes as well as from the payroll contributions of employer and employee was urged.

Finally, disinterested critics generally felt that the bill permitted too centralized an administration of the program. They said that the program did not require sufficient participation by state and local governments nor by local representatives of the professions and the public. The American Bar Association made the additional point that it failed to provide for court review of administrative decisions.

A revised Wagner-Murray-Dingell Bill, introduced into Congress in May, 1945, proposed a pattern essentially similar to the earlier one, but has added features which meet some of the criticisms made of the original.

These health provisions include, besides medical care insurance, increased federal grants to the states for public health work and for the care of mothers and children, but no funds for construction of hospitals and health centers. Benefits of the medical care insurance have been increased by adding limited home nursing and dental care. An attempt has been made too, to increase the responsibility of states and communities, although the final administrative control remains in the federal government. Court review of administrative decisions

is, however, specifically authorized.

Groups of physicians, as well as individual practitioners, may participate in the plan but they are not expressly encouraged. The physicians of an area may still decide by vote how they wish to be paid, but such a vote is no longer binding upon all the doctors of the area. General taxes are to be used more generously to supplement the funds contributed by employers and employees, but the plan does not yet cover the entire population.

Discussion of national legislation for health will doubtless be focused about the Truman proposals and the latest Wagner-Murray-Dingell Bill for some time to come. It will be useful, therefore, to repeat the principal arguments for and against the original bill. The groups supporting the 1943 measure emphasized the necessity for nation-wide action in order to equalize the opportunity for health service among all groups of the population in whatever part of the country they happen to live. They also stressed the need for a method of paying for medical service by which people can pay in known, regular amounts, month by month, in accordance with their own earnings.

Those opposed to the first bill, on the other hand, made an issue of the danger of political control over medical matters, of a possible threat to the individual freedom of patients and doctors, and of the limitations that it might impose upon physicians in professional status and--by implication--

income.

The nation-wide discussion that took place as a result of the introduction of the bill has broad educational value. It stimulated people everywhere to greater awareness of the issues. It provoked painstaking inquiry by numerous nonprofessional organizations and groups as to the true facts of medical care in their own communities and in the nation as a whole. All this served in some degree to clear the air, to dispel any false notions and groundless fears, and to aid the country in facing realities.

A fourth revision of the Bill was introduced into Congress, S 1320, May, 1947; some of the more important new proposals in it are provision for payments of dental care, nursing care, and expensive medicine and drugs. Funds for the construction of hospitals have been designated. Hospitalization has been extended to sixty days; however, no person having tuberculosis or mental illness can be hospitalized longer than thirty days under this Bill.

3. The Eliot Bill

The Eliot Bill was introduced by Representative Eliot, of Massachusetts on September 9, 1942--House Bill 7534, 77th Congress, Second Session. The bill would extend the old-age insurance benefits to agricultural workers, domestic servants, and to self-employed groups.

It would federalize the present system of unemployment insurance increasing the amount of unemployment benefits, extend-

ing the period for payment of benefits, and making provision for additional benefits to dependents.

It makes provision for more liberal unemployment benefits for men discharged from military service than are provided in the present statute.

It would establish a federal health insurance system in two areas, permanent disability and temporary disability.

With the three bills before us, the following observations may be made; these proposals represent three different types of thought with reference to governmental jurisdiction in the field of health insurance, the Wagner Bill providing for relatively independent state systems, subsidized by the Federal government; the Capper Bill providing for state systems, with a larger amount of Federal participation and control; and the Eliot Bill establishing a completely Federalized system. None of these bills have been passed by Congress.

4. Public Health Service Act

On July 1, 1944, the President signed the Public Health Service Act. A milestone in the 146-year history of the Service, this law strengthens the national structure of Federal-State cooperation in the provision of health services to the people.

The new law streamlines the functioning of the Public Health Service under both wartime pressure and the demands of peace. It again confirms the approval by Congress and the President of a closely-knit, highly-trained commissioned corps of officers as the type of organization best suited to deal

with national and international health problems. This structure has been expanded by the commissioning of scientific personnel and nurses,--professional groups that play such important roles in both civilian and military health services.

Through its research branches, the Public Health Service has made important contributions to the great advances in medical and public health science during the twentieth century. For the past four years, virtually all of its clinical and laboratory research has been directed toward problems related to the war. Knowledge of many diseases remains incomplete; however, future progress demands coordinated programs of painstaking, laborious research. The Public Health Service Law gives the National Institute of Health the authority to develop such programs in the same way that coordinated cancer research has been developed in our National Cancer Institute with Federal grants-in-aid to responsible institutions.

One of the most significant and far-reaching provisions of the law enables the Public Health Service to extend its leadership and assistance to the States in a Nation-wide attack on tuberculosis. The law authorizes a national tuberculosis control program in the Service, with the responsibility of administering grants-in-aid to the States, training of personnel, and conducting research leading to the eradication of this needless cause of sickness and death.

Finally, the new law augments Federal support of State Health organizations. It authorizes the Public Health Service

to use a limited portion of appropriations for general health work to train personnel and to develop solutions for particular community health problems.

One of the serious defects of our present organization of the social structure is that the resources of the community are largely concentrated on aiding the deprived or under-privileged stratum of society or on serving the people of wealth who have at their command the means with which to secure any professional aid which they may feel they require. For members of the great middle class there are few opportunities to avail themselves of skilled help in the baffling problems which confront them.

Planning for adequate medical care is more than a method of organizing the application of scientific knowledge and technical skill. It is the expression of a social philosophy. It is effective only insofar as it is sustained by a conviction of principles. The philosophy underlying modern health policy rests on two cornerstones: society's need of the fit and productive individual; and the individual's right to health. This concept recognizes the reciprocity of health and economy; the interdependence of the individual and the state, as well as their mutual obligations; and the need for social action substituting solidarity for isolated individual effort.[10]

In the first full-length presidential message on health ever submitted to Congress, President Truman, on November 19,

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10 Franz Goldman, Public Medical Care, p. 196.

1945, urged the representatives of the American people to give careful consideration to his proposal for the establishment of a national health program for better distribution of both professional personnel and medical care facilities; improvement of public health services; promotion of medical research and professional education; development of organized payment for medical care; and protection against the economic risks of disabling illness.

The reading of the presidential message was followed by the introduction of a new Wagner-Murray-Dingell Bill, the third measure to be sponsored by this triumvirate within the last three years and one of a large number of health service bills offered in 1945. The most important of the other legislative proposals introduced in Congress were the following, listed in chronological order: (1) the Hill-Burton Bill, proposing a nation-wide program of construction of hospitals and related facilities; (2) the National Institute of Dental Research bill, designed to promote research in dental diseases; (3) the National Neuropsychiatric Institute bill, to foster research and to develop more adequate services for the prevention and treatment of neuropsychiatric disorders; (4) a bill proposing the development of dental health service programs throughout the nation; (5) the Pepper Bill for maternal and child welfare, proposing complete health service, including medical care, for mother during maternity and children up to twenty-one years of age through a system of general taxation;

and (6) a bill for the promotion of research in cancer and poliomyelitis.

The writer feels that adequate medical care is a fundamental human right. It is as much a necessity of life as food, shelter, clothing, or education. It is no less indispensable to the well-being of society than to the welfare of the individual. It is an essential component of any program for individual and social security.

5. Hill-Burton Hospital Survey and Construction Act

August 13, 1946 the Hill-Burton Hospital Survey and Construction Act became law. This law provides federal grants up to $3,000,000 to states for the construction of hospitals and health centers. Designed to encourage over-all planning by the states of an ordered network of health facilities, the bill calls for each state to study its existing hospital resources and unmet needs, in order to develop a master plan of construction. The federal treasury, after state plans had been approved by the Surgeon-General of the United States Public Health Service, would supplement funds for construction raised within the states, paying a larger share of federal funds in poorer states and a smaller share in richer ones.

Besides providing for the construction and improvement of state, city, and county hospitals for general care, mental illness, and tuberculosis, this bill would also aid in the construction of those nongovernmental community hospitals which are not operated for profit.

The most serious criticism of the Hill-Burton Bill is that it can meet only limited needs. It does not attack the problem of paying doctors' and hospital bills. At present, it is the sad truth that areas which have the least hospital facilities in proportion to population are also the areas where such hospitals as do exist are the least used. In other words, where communities are too poor to build adequate hospitals, the people living there are too poor to pay for hospital care under present arrangements. To guard against the possibility of putting up white elephants, in the shape of hospitals which would not be used, this bill provides that communities wanting new hospitals must show ability to support them after they are built. If this cannot be shown, no federal money would be forthcoming.

According to the subcommittee on Wartime Health and Education's report, January, 1945, the Surgeon General of the United States Public Health Service urged development of a coordinated network of four basic types of medical center facilities--the small neighborhood or community "health center," the "rural hospital," the "district hospital," and the large "base hospital."

The physical structures required for many of these four basic types of units already exist in many areas. Here the primary need is for regional planning and organization of the existing facilities so that they might function in a coordinated manner, rather than for the construction of new buildings.

In some places, minor alterations, renovations, or addition of new wings, might suffice to convert existing public or voluntary institutions into units of the coordinated regional plan.

The smallest unit, the health center, might include offices for local physicians and dentists; facilities for emergency medical and surgical work; a small number of beds for obstetrical care; laboratory facilities for X-ray, blood, and bacteriological procedures; and health department offices, and clinics where these are not otherwise provided.

The rural hospital, located within easy reach of several health centers, would be larger than the health center and would provide additional basic medical, surgical, obstetrical, and laboratory services. The size of the rural hospital would depend upon the needs of the area it served, but it should be a modern nospital in every sense of the word.

Finally, as the hub of each major medical service area, there would be a large base hospital. The base hospital would be a teaching hospital, staffed with experts in every medical and surgical specialty, equipped for complete diagnostic services, and designed to conduct extensive postgraduate work and research. Besides its general hospital beds, it would have, either on its premises or nearby, facilities for institutional care and study of tuberculosis, nervous and mental diseases, contagious disease, and orthopedic and chronic disease. The benefits of the research carried on in the base hospital would be passed on to the smaller units in the network, and there

would be constant back-and-forth referral of patients and diagnostic information, as well as interchange of personnel, between the large center and the smaller institutions.

With such graded networks--the health center, the rural hospital, the district hospital, and the base hospital--covering the entire country, facilities would be available through which every person, regardless of where he lived, might receive (a) immediate diagnosis and care for the common, relatively simple ailments and (b) easy access when necessary to the more complicated types of medical service.

According to careful estimates made by the United States Public Health Service, facilities are needed for 100,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds. In addition, 66,000 general beds, 97,000 nervous and mental disease beds, and 16,000 tuberculosis beds are situated in hospitals that are obsolete and that should be replaced. Approximately 2,400 modern structures are needed to serve as headquarters for local health departments.

A program for construction of these facilities would have to be well-planned and well-coordinated, in order to avoid the mistakes which characterized the construction boom following World War I. Areas which need hospitals most should be given priorities for building materials and surplus medical supplies. The hospitals should not only be planned and built along modern functional lines, but should be staffed and maintained so as

to assure a high level of operating efficiency. Voluntary and public hospitals should work together in a coordinated manner. Both, in turn, should cooperate with the health department and private practitioners.

The cost of an adequate health-facilities program cannot be borne by the States and localities alone. Federal grants-in-aid to the States on a basis of need will be necessary.

6. Taft-Smith-Ball-Donnell Bill

It is impossible to discuss very completely the various features of the Taft-Smith-Ball-Donnell Bill 5545 introduced May, 1947. However, certain provisions of the bill should be particularly pointed out, notably the bringing together of all the scattered health activities into a national health agency headed by an outstanding physician; determination of actual medical needs by requiring state surveys financed from federal funds--this is a highly desirable feature; provisions of grants-in-aid to states also making some contribution for the extension of medical care to people unable to pay for it; encouragement of voluntary payment plans; the provision for voluntary payroll deductions of federal employees; periodic examination of school children; and provision for encouragement and grants-in-aid to certain types of research, properly directed.

According to a statement by Dr. R. L. Sensenick before a hearing on May 21, 1947 of the Subcommittee on Health, governmental measures at the top are too far removed from the local

community and the individuals and are even with the best intent inadequate or restrictive in their application.

So much is dependent on the education, the interest and the voluntary effort of the individual that elevation of standards and program must be accomplished by local stimulation of effort and cooperation of these individual units in the community. Legislation cannot accomplish those ends. No pattern can be established at the national level that can be practicably applied to the varying conditions in each local community; nor can national regulations deal adequately and fairly in the determination of local need or the application of proper local remedies. Dr. Sensenick feels that effective approach to the problem will rest on the voluntary efforts awakened by stimulation of interest, and development of methods and assistance as demonstrated. It would seem that any legislation directed to this field would be largely concerned with providing financial assistance where need can be demonstrated and the setting up of safeguards to determine equable distribution of that assistance. Contribution from state or local levels should be required in proportion to financial ability. It will be necessary to leave to the local community the administration of local measures without introduction of bureaucratic controls or political interference.

The subcommittee on Wartime Health and Education said it recognizes the complexity of the task of providing good medical care to all the people. There are three necessary methods

pf approach to the task of providing good medical care to all the people. One approach without the others would be unrealistic and ineffective.

The first involves education of the people, of the professions, and of the Government. We must collectively accept the fact of widespread existence of disease, disability, and injury, much of which medical knowledge today is able to prevent, alleviate, or cure.

The second approach is through legislation. There is urgent need for modern medical facilities in many places throughout the Nation, especially in rural areas and in crowded war-industry communities. To meet these needs money must be provided, and Federal financial assistance will be necessary.

The third approach is through better organization of medical services. There is wide agreement that improved organization would result not only in a higher quality of service but in considerable economy of time, effort, and money. The necessary reorganization can best be achieved, and the welfare of the professions and the public advanced, by regional planning such as that provided for in the health and medical center proposal set forth above.

Finally, attention must be drawn to a factor which is beyond the control of medical science. Many expert witnesses emphasize that full employment and adequate social security are indispensable to a truly effective health program. This is especially so in regard to mental health. There is nothing so

detrimental to a person's morale and self-confidence as idleness and the feeling that he has no useful place in the scheme of things. It may be too much to say that idleness causes mental or physical disease, but it provides fertile ground for development of fears, anxieties, and a sense of insecurity. All of these factors are known to have a profound effect on man's resistance to disease.

If there is actually a threatened shortage, it would seem that there must be in the United States the few thousand persons of the age, caliber, and training needed to raise annual premedical and medical school enrollments to the number required for the duration of the war emergency. Moreover, certain barriers and prejudices which limit enrollments could be removed. The financial barriers which face many prospective students could be overcome by more adequate scholarships or by loan funds. Some qualified students cannot gain admission to medical schools because of tacit racial or religious discrimination. Lastly, there is a great untapped source of future doctors among the women of the Nation. We are unable to discover any compelling reason for the failure of this country to utilize its womanpower to prevent what is claimed to be a serious future shortage of physicians. Other nations have done so; we have simply never tried.

Some provisions for periodic and systematic study of new methods of clinical practice should be made, particularly for participants whose communities do not afford such opportunities

and whose economic status does not permit leisure for such purposes. Short periods of study at frequent intervals, or longer sessions at wider intervals, might properly be considered an indispensable adjunct to maintenance of the highest level of professional competence.

A greater number of substantial postgraduate courses should be made possible for participating practitioners who want and need opportunities for specialization. Although we already have more physicians engaged in specialties, full time and part time, than are needed according to professional judgments, we still have too few in certain fields of specialization and too few specialists in many geographical areas. Education and training opportunities should be provided to fill the existing gaps.

CHAPTER III

Mental Health

A. Definition

Mental health implies an adjustment of human beings to themselves and to the world at large with a maximum of personal and social effectiveness and satisfactions. The highest degree of positive mental health permits the person to realize the greatest success which his capabilities will permit, together with the maximum of satisfaction to himself and society and a minimum of friction and tension.

There is no sharp line irrevocably dividing those who are mentally ill from those who are mentally healthy. The two conditions shade into each other by minute graduations, and the precise point at which mental health passes over into its opposite, mental ill health, depends on social judgments that vary with time and place. Those gifted with the best of mental health present more or less discernible flaws, commonly called "peculiarities" or "difficult spots".

In spite of the desirability of promoting positive mental health, it must nevertheless be admitted that the present state of public opinion, the scanty financial and personnel facilities available, and the presence of vast and pressing problems due to mental ill health make it necessary to develop a program. Any program that is immediately practicable must have as its chief emphasis the alleviation and prevention of recognizable mental ill health.

The early detection and treatment of these lesser mental maladjustments would strike at the very root of many of our most pressing social problems, for these problems often have mental health implications.

In addition to insanity, mental ill health includes a variety of borderline states, particularly certain kinds of delinquency, prostitution, vagrancy, and dependency. These are misunderstood and tradition labels them from rigid, moral, or legal points of view.

B. Causes

Mental disorders are often caused by injuries, infectious diseases, and distinctive processes of the neurological structures. Little is known of the causes of these organic disorders (which constitute an important part of the problem and are responsible for some of the most stubborn types of mental abnormalities). The acquired functional disorders, however, account for the majority of cases of mental ill health. The fact that they have often been successfully dealt with by special non-organic measures opens up a wide range of possibilities for furthering mental health.

Because many, if not most organic disturbances wreak their greatest havoc in the years of childhood, and because situational factors that distort personality development exercise their greatest effects during the first six or seven years of life, the mental hygiene of the future must concentrate on the childhood period. The striking results achieved by early workers in the field have demonstrated the value of

this new approach, for the plasticity of the human organism during childhood makes possible not only the inculcation of desirable character traits, but also the modification of undesirable traits already established. Hence, childhood has aptly been termed the golden period for mental hygiene.

C. Methods Used to Promote M ental Health

There are four major fields[11] in which facilities for promoting mental health are now operative: remedial work for the mentally ill; therapeutic prevention; constructive prevention; and research.

There is urgent need for remedial work for the obviously mentally ill, through a wider extension of facilities for the care of early and acute cases of the graver mental disorders of all age groups. This may be done through psychiatrists and psychiatric ward facilities or departments in general hospitals, psychopathic hospitals, and state mental hospitals. In one way or another there should be provision for competent medical and nursing care with a minimum of restraint and legal formality.

Therapeutic prevention, that is, proper treatment of minor maladjustments through out-patient clinics, child guidance clinics, habit clinics for preschool children, and marital clinics, may prevent graver disorders.

Constructive prevention is a zone of effort largely educational, and is directed to adults in the effort to prevent

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11 White House Conference, 1930, p. 305.

their causing mental difficulties in children (indirect approach); and to the children themselves, thereby helping them to prevent or solve their own difficulties (direct approach).

In the case of adults an indispensable part of a practical program for any community is mental hygiene education, emotional and intellectual, for the adults who control the environment of children through: comprehensive education for professional child workers; general adult education; and pre-parental and parental education.

In the case of children, constructive prevention may be carried on, in addition to adult influence in general, through nursery schools, kindergartens, and other preschool organizations; organizations of public school programs so that they center about the child, his capabilities, and his adjustment to life rather than about subject matter; education of grade-school children in the principles of social relationships; and courses on personal mental hygiene in colleges.

Extensive research in problems of mental health is urgently needed if mental hygiene is to attain its maximum usefulness in everyday life. Another vital need closely akin to research is for the systemitization of knowledge relating to mental health problems.

The primary responsibility for a practical mental hygiene program ultimately rests upon local communities, which must be properly guided. A vital requisite is a strong state agency for the direction and control of the more general aspects of the work of local agencies.

Moreover a community must be properly equipped in other fields--educational, social, health--and organizations in this field must be doing their share if mental hygiene clinics are to function properly. The community must organize itself as a whole in order to ensure the carrying out of clinical recommendations, and more especially, in order to provide all types of recreational, cultural, and social opportunities in the development and organization of personality. Studies of delinquent areas have shown just how important the physical environment and the material culture in which the child develops may be.[12]

It might be helpful at this point to delve more deeply into a discussion of the four zones of the remedial and preventive program.

Psychiatric wards or departments in general hospitals may be of great service in first aid for mentally ill even when a state hospital is nearby. Also in remedial work for the obviously mentally ill, psychopathic hospitals may be utilized to great advantage. These are small, highly specialized hospitals functioning quite similarly to those of the psychiatric departments of general hospitals. They rarely have more than two hundred beds, and deal exclusively with patients suspected of or definitely afflicted with mental disorders. Psychopathic hospitals are almost always located in large cities, where they have the best opportunity to serve patients who would otherwise

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12 White House Conference on Child Health and Protection, Committee on Physically and M entally Handicapped, p.298.

have to be sent to psychiatric wards in general hospitals or directly to large district state hospitals. The psychopathic hospital can admit patients quite as informally as can the psychiatric ward of a general hospital; it is small enough to give individualized treatment, something extremely difficult for large state hospitals, yet important in the early stages of most mental disorders; it is large enough to maintain a staff of psychiatrists, psychologists, and psychiatric social workers, which is rather difficult in a mere department of a general hospital; finally it can most easily be linked with the teaching and research functions of graduate schools offering instruction in psychiatry, a linkage which is beneficial to student, teacher and patient.

Psychopathic hospitals also act as clearing houses; some cases are returned to the community; others requiring extended treatment or custodial care are sent on to the state hospitals.

Hospitals for maladjusted children needing extended observation and treatment should be available in every state. There are few wards or departments devoted to this purpose in state mental hospitals, and fewer whole hospital units specifically designed for the care of children. In addition to all facilities provided for treatment by psychiatrists, psychologists, and psychiatric social workers, academic, occupational and physical education that makes the most of all the capabilities of the child should also be provided.

Child guidance clinics which are used in therapeutic prevention, serve schools, agencies, and parents, and deal with

general behavior disorders such as tantrums, stealing, over-sensitiveness, day-dreaming, cruelty, restlessness, morbid fears, and so forth.

The child guidance clinic is organized about a three-fold nucleus of a psychiatrist, who is usually medical examiner as well, a psychologist, and a psychiatric social worker.

Child guidance clinics may also be helpful in dealing with children or young adolescents paroled from hospitals and scheduled for eventual discharge from custody. They should not only have the help of professional social workers who visit them periodically, but should also have the benefit of periodic clinical treatment designed to help them effect successful adjustment to their home communities. In many instances a return to the hospital may not only be prevented but the degree of success achieved in adjustment may be greatly increased. Clinics of this sort should be available in all juvenile courts and other agencies dealing with children.

The child guidance clinic may prove helpful in giving advice and minor treatment to adolescents who feel in need of it but who shrink from more formal procedures which may bring them to public attention, or which deal with their cases from the legal viewpoint of insanity. The extent to which adolescents avail themselves of these consultive opportunities depends upon the extent to which the existence of such opportunities has become known to the community. A vigorous campaign of education will do much to spread the knowledge.

Although child guidance clinics deal with preschool children as well as with those of school age, habit clinics treat preschool children exclusively and, as the name implies, deal with habit difficulties such as bed-wetting, thumb-sucking, food dislikes, temper tantrums, and so forth. Such apparently minor difficulties often develop into definite behavior problems by the time the school age is reached. Habit clinics often function in conjunction with nursery schools and kindergartens, but not more than one child in six attends any of these. Such clinics must draw on the much larger proportion of children who do not attend them if their efforts are to count for much in the community. These clinics are extremely valuable agencies, for they reach the child in the most plastic period of life.

The teaching of the principles of mental hygiene as related to their own work should be a part of the training of those professional groups, pediatricians, general medical practitioners, nurses, public health officers, teachers of regular and special classes, visiting nurses, educational counselors, vocational guidance workers, school psychologists, school administrators, social workers, policemen, probation officers, juvenile court judges and similar officials, church workers, boys' and girls' club workers, playground supervisors, and so forth, whose work brings them into intimate contact with large groups of children. These persons often make great efforts to help problem children coming to their attention, but since they sometimes lack knowledge of proper emotional attitudes, they

may fail to help and even harm such children; moreover, they may inadvertently harm mentally healthy children as well. Hence the need for training in the basic principles of mental hygiene.[13]

If professional groups alone were relied upon, public health work could not progress very far. The wisdom of large scale advertising campaigns to acquaint the public at large with elementary health facts has already been amply demonstrated. The same is true of any program for furthering mental health; it must include lectures, radio talks, sermons, distribution of literature, newspaper and magazine publicity, and every other legitimate means of reaching the public. Women's clubs, men's luncheon clubs, fraternal organizations, church societies, and similar bodies should be given mental hygiene information and should, if possible, be persuaded to aid in its further dissemination.

So far the discussion has been cast in terms of institutions and their community function. It seems desirable to indicate also what local communities can do immediately to advance the program already outlined.

The first step is to institute psychologic testing in the schools; this is an indispensable minimum which even the poorest community should not neglect. Psychologic testing makes possible differentiation on the basis of possible achievement rather than on that of chronologic age, gives some indication of the handicaps, mental and physical, under which children are laboring, and prevents the application of unnecessarily severe

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13 Ibid, p. 309.

disciplinary measures which may further accentuate existing difficulties. No single test, however valuable, is sufficiently infallible to determine the future destiny of any child; careful clinical diagnosis by psychiatrists, psychologists, psychiatric social workers, and sociologists must compliment the preliminary intelligence tests. If sufficient caution is practiced, however, intelligence testing is an extremely valuable preliminary step and should be immediately instituted by every community not now making use of it.[14]

Next, extramural clinical facilities, child guidance clinics, habit clinics, outpatient clinics, should be made available by the establishment of mental hygiene clinics in communities or other suitable units. These clinics can organize the mental health work of local communities and call in traveling psychiatric clinics, outpatient clinics, and similar agencies which the local community if small, could not itself maintain.

The child guidance clinics have yielded the most research material, not only because they embody a program and method of handling behavior problems of childhood which is recommended by the country's foremost psychiatrists as one of the best means for diagnosis, treatment, research, and education of professional groups and the community, but also because the child guidance clinics have the most clearly drawn-up records and the most sharply defined objectives.

Extension of census surveys, agencies publicly and privately financed, national promotional bodies, ready cooperation

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14 Ibid, p.312.

on the part of the community agencies, and an informed public opinion are all necessary if research designed to promote mental health is to be advanced.

The stimulus to research must come from a variety of sources. State bureaus afford only one source; second and even more important are the medical schools and the hospitals with which such schools are affiliated; the importance of the psychopathic hospital has already been noted. A third source is the public school system, which in conjunction with preliminary and clinical diagnostic facilities, may greatly advance our knowledge of maladjustments in their very earliest stages.

D. Handicapped Children

Institutional care must be provided for all the feeble-minded who cannot care for themselves or make suitable adjustments in the community and whose parents cannot provide suitable care or surroundings for them; no state is too poor to shoulder this fundamental responsibility.

The purpose of training mental defectives in institutions is to give each child the opportunity to develop to the limit of his capacity; to render mentally deficient children easier to live with and less expensive to care for in case they cannot achieve social self-direction and support; to prepare high grade mentally deficient children for return to the community as self-supporting and well disposed members of society.

Instead of being compelled to compete with children who far surpass them in achievement, mentally deficient children in institutions work and play with others of their own level, thus

avoiding many personality difficulties. In practically all institutions they are trained in emotional control through parties, clubs, and so forth. Persistent effort in dealing with untidiness, bad table manners, and violations of common decency are often successful.

The White House Conference on Child Health and Protection felt that no inflexible statutes should be tolerated. Laws a uthorizing the establishment of school clinics reaching every public school district throughout the state should be enacted. The formation of special and differentiated classes should be authorized. Admission to state institutions should be passed upon by boards of experts and not by the outworn advice of jury trial. Every consideration should be given to voluntary commitment. Parole laws and statutes permitting colonization should be established. Sterilization statutes with satisfactory terminology defining persons to be sterilized and describing method of operation should be passed. The mentally ill should be definitely distinguished from the mentally deficient. Provision for a state department of research should be made. In short, everything should be done which will facilitate the application and administration of all agencies dealing with mental deficiency.[15]

There should be sufficient flexibility in the vocational training program to enable the schools to utilize supervised employment for training purposes in lieu of full-time attendance at school wherever this appears to be the best course for

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15 Ibid, p. 377.

the given individual.

For those handicapped persons who can be vocationally trained in the public day schools, the related educational subject matter will naturally be given there, concurrently with the technical skills. For those who are being trained on the job in industry, provision should be made to have the related educational matter taught in part-time schools.

During the period of vocational training, whether in the school or in industry, the handicapped child requires continuous guidance and supervision.

A special service of placement in employment must be provided for the handicapped child. This service must be the focal point for all other services rendered the individual handicapped child and is the supreme test of any program for promoting the social and economic adjustment of the handicapped.

In order to provide a knowledge of employment opportunities in the community and to secure the cooperation of employers, surveys of commercial and industrial establishments should be made. The jobs in these establishments should be analyzed to discover the physical, mental, and temperamental qualities and abilities required to perform them.

The final step in the social and economic adjustment of the handicapped is proper follow-up work. The period immediately following placement is one of adjustment to the environment of employment. Minor adjustment of habits and attitudes often are required to help maintain the handicapped person's

morale. The handicapped child needs the assistance of persons who understand these problems of adjustment. Follow-up should be an extension of the guidance and placement service and it should continue until the child is reasonably adjusted to his employment and environment.

Since the nature of the work of adjustment of physically and mentally handicapped children requires the technical services of the health, education and labor departments, and specially the general social services of well organized departments of welfare, it is suggested that the state welfare department be designated as the central state coordinating agency to exercise general supervision over the work for the handicapped, by setting up an administrative council which will effectively unite the services for the handicapped carried on by other state departments, particularly health, education and labor, and which will integrate into a unified state program the efforts of local health and social work agencies and of voluntary organizations interested in the handicapped.[16]

It is vital to develop a program of education which reaffirms the principle that handicapped children are not peculiarly set apart from other children and that their needs are the common needs of all children, although because of some physical or mental handicap they require a more intensive application of medical care and of social, academic, or vocational education.

The following definite objective must be included in the

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16 Ibid, p. 429.

program for the development of constructive attitudes:[17]

> Parents must be encouraged to assume the same attitude towards their handicapped child as toward their normal child.
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> The school authorities must be made to appreciate the fact that a handicapped child is a potential social asset and that his development must proceed to the maximum of his capacity. Educators must also realize that, although differentiated training methods and procedures are required to meet the physical and mental limitations of the handicapped, the goal of education, the social and economic competency of the child, is essentially the same.
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> The public must come to appreciate the fact that the handicapped child not only has the same inalienable right to an opportunity to develop to the maximum of his capacity but that it is the particular duty of society to provide the child with that opportunity. The social and economic contribution which this large group of handicapped children has to make must be pointed out.
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> It must be demonstrated to employers that handicapped persons who have been adequately prepared by education may become competent, dependable, and loyal employees.

If the child can be reached young enough there is much that can be done at least to aid the personality to develop in the right direction by eliminating at the very beginning of their appearance, faulty habits and reactions and by fostering right attitudes and reactions. Even if the qualities that go to make up personality are regarded as innate and unchangeable, it is apparent from work already done that it is possible to change the manifestations of personality in behavior, which is, after all, the thing with which we are concerned.

The school which merely concerns itself with its mentally handicapped pupils during school hours, and fails to maintain a close and helpful contact with the child's extra-school environment, is closing its eyes to the larger part of the task.

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17 Ibid, p. 430-431.

The visiting teacher, aside from understanding the point of view of the teacher and of the school, should be a trained social worker who knows how to call to her aid all available resources in studying the child's personality and problems as seen in school and out, in tactfully bringing about improvements where needed in the family situation and home conditions, and in putting the child in touch with the right kind of neighborhood and community influences.

The chief means of treatment are special classes for the feebleminded, differentiated education for the intellectually subnormal, institutional care and training, and colonization and parole.

It is to be hoped that before many years the public school through special classes and other pedagogic provisions, will be so organized to deal with mentally deficient children that it will be the largest and most important single agency in developing them for social and economic usefulness and in preventing social failure.[18]

E. Extent of Mental Illness

Dr. Thomas Parran, Surgeon General of the United States Public Health Service,[19] estimates that 8,000,000 people, more than six per cent of the population are suffering from some form of mental illness. About 125,000 new cases of mental

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18 Stanley Davies, Social Control of the Mentally Deficient, p. 306.

19 Donald M. Sullivan, "Congress' Failure to Appropriate Means Years' Delay in Starting Mental Health Program," Boston Daily Globe, September 3, 1946.

disease are admitted to hospitals each year.

It costs money to take care of people who cannot take care of themselves. In 1942, total budgets of public psychopathic hospitals were more than $170,000,000.

In 1943 and 1944 the National average annual cost of care per patient in public institutions was $335.84 and $366.25. A bill for a year's care in a good private institution runs into the thousands. So, for all but a tiny fraction of the population any prolonged mental care must be found in Federal or State government facilities.

Dr. Abbot[20] states that mental hygiene needs to be, and to some extent is, applied in or to the following institutions or organizations:

> "The home, to secure good attitudes, examples, atmosphere, and so forth for both adults and children..."
> "The school, to secure good health conditions, understanding by teachers of pupils' personality needs, studies adapted to each pupil's needs and abilities,etc..."
> "Industry, to secure good health conditions, harmonious relations between management and employees and among employees, work and workers fitted to each other, understanding for and consideration of the misfit..."
> "The courts, juvenile and adult, to secure better understanding by all court officers of the mental, personal, social and other environmental factors in delinquency and crime, better consideration of individual needs and of the probable effects of punitive measures..."
> "Penal and reformatory institutions, to secure better knowledge by all officials of the individual needs of inmates, better attitudes toward them, better classification, employment and segregation, etc..."
> "Hospitals, general and special, almshouses, orphanages, etc., to secure a favorable mental atmosphere, promote

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20 E. S. Abbot, "What is Mental Hygiene?", American Journal of Psychiatry, 4:261-284, October, 1924.

self-respect and self-confidence in the inmates, to develop the best adjustments of which they are capable, etc..."

"The church, to secure elimination from its forms and teachings of the mentally unhygienic concepts of original sin and 'no health in us' passages of revenge, hate and intolerance in Psalms, etc..."

"Peoples and nations, to secure lessening of race conceits, prejudices, antagonisms, jealousies, injustices, and desires for revenge, in order that they may understand each other better, and thus lessen the liability for wars..."

The persons by and to whom mental hygiene principles need to be applied, Dr. Abbot lists as follows:

"Parents, that they may make good homes, set good examples, wisely guide the development of their children and avoid injudicious ways and words with them."

"Children, that they may form the best habits, attitudes, and aims, learn self-understanding and self-control, and acquire such knowledge and the ability to use it as will enable them to handle their internal conflicts and adjust themselves well to the conditions of life."

"Teachers, that they may live their own lives efficiently, understand children, adapt studies to each child's needs, and develop the best methods of teaching."

"Employers and managers of workers, that they may develop favorable conditions for work and workers, and adopt good attitudes toward workers."

"Employees, that they may be better adjusted to their work and develop better attitudes toward their work, each other, and their employers and other official superiors."

"Physicians, that they may understand better the mental factors in their patients' illnesses, recognize the beginning of mental illness, and advise patients more wisely."

"Clergymen, that they may better understand the consequences of marital incompatibilities (sexual and temperamental) in the couples they contemplate joining in marriage, distinguish between sinfulness and illness or other condition in the self-accusations or mental or social maladaptations of some of their parishioners..."

"Judges, that they may have better understanding of the mental and social factors in delinquency and crime and the reform of delinquents, know the aid mental clinics can give them, and understand the use of expert testimony."

> "The public in general, that it may take interest in, use, and support measures for the promotion of mental health, take a more hopeful and understanding attitude toward the mentally ill, and support measures and institutions for the better study and care of mental patients and other poorly adjusted persons."

The organizations which are now primarily concerned with problems of mental health are many and varied. Because in earlier and more ignorant decades only the grossest conditions of mental disease and defect were recognized as needing attention, the oldest agencies in this field are hospitals for mental diseases and institutions for mental defects. The numbers of such institutions, although still inadequate to meet present needs, have greatly increased and they perform an essential function in any community program for mental health. As an extension of hospital service, out-patient psychiatric and neuropsychiatric clinics have been more recently established to diagnose and treat patients with mental disorders which have not yet reached the stage of requiring hospital care and at the present time hundreds of such clinics are in operation. After considerable clinical experience in the study and treatment of maladjusted adults, child guidance clinics have been established to handle at an even earlier period the incipient personality and behavior disorders of childhood. Mental health clinics are now available in some communities not only for the treatment of adults and of children of school age, but of infants and children of the pre-school age. The practice of social supervision of patients discharged from hospitals for mental diseases and institutions for mental defects, the development

of psychopathic hospitals as centers for the treatment of acute mental conditions, for research and for the training of professional personnel, the development of psychopathic wards in general hospitals are innovations which have been developed during the same period.

The organized movement for mental hygiene began in 1908 with the organization of the Connecticut Society for Mental Hygiene and in 1909 the National Committee for Mental Hygiene was formed to carry on the work on a national scale. City, county, state, national and international societies and committees for mental hygiene are now engaged in the promotion of mental health. With the development of numbers of state institutions and agencies engaged in mental health programs, state departments or bureaus of mental hygiene were established to develop and coordinate these programs on a state-wide basis. As the possible applications of mental hygiene to various social problems became more apparent, mental health clinics have been established in various communities as an integral part of public and private educational systems and institutions of primary, secondary and higher grades; of social service agencies; courts and institutions caring for dependent, neglected and delinquent; of social settlements; day nurseries; nursery schools; churches and industrial organizations. In each of these settings the principles of mental hygiene have been applied to the special types of social problems under the care of the particular agency and increased understanding of many

varied mental health problems has emerged.

With accumulating and deepening knowledge and experience in the study and treatment of mental disorders, it soon became clear that if any genuine headway was to be made in the prevention of maladjustment and in the promotion of positive mental health, other professions and individuals especially responsible for the study, training and guidance of personality must share in the process. Courses in mental hygiene are, therefore, increasingly being incorporated into the training curricula for doctors, lawyers, ministers, teachers, nurses, social workers, probation officers, prison officials, industrial executives, and parents as indispensible in preparation for their subsequent work.

Many individuals, committees and communities are vitally interested in organizing and improving facilities for the study and treatment of mental disorders and in developing a broad program for the promotion of mental health.

Hearings on the National Mental Health Act were referred to the Committee on Education and Labor; before this committee came leaders in the field of medicine to testify for and against the Act. It was pointed out that one-half of all the hospital beds in the United States are occupied today by mental patients. Today more than 600,000 persons are hospitalized for mental diseases and over 125,000 new cases are admitted each year.

These figures, however, are by no means indicative of

the total amount of mental illness or even the number of patients who are totally disabled by it. Prewar studies show that at any one time there are about 1,000,000 permanently disabled by mental illness and another million temporarily disabled by it. It is estimated that 10,000,000 of the current population will require hospitalization for mental diseases at some time in their lives.

These data, which include the more seriously ill, do not reflect the vast majority of milder cases which now receive no psychiatric treatment. It has been estimated that today about six per cent of the population, or approximately 8,000,000 people--more than the entire population of New York City, suffer from some form of mental illness.

The experience of the Selective Service System and the armed forces during the war also demonstrates the seriousness of the mental health problem. The Director of the Selective Service System testified that about 1,100,000 persons were rejected for military duty because of mental or neurological diseases or defects--by far the largest single group of causes for rejection.

There is evidence, also, that the number of mental cases is increasing out of proportion to the population increase. While the rates for a given age group is probably no higher than in the past, the steady increase in the average lifespan is probably responsible for this rise since the incidence of mental disorders increase with age. The number of persons of

sixty-five and over is expected to double within the next forty years as compared with an over-all population increase of only about twenty-three per cent. Unless positive steps are taken, we must, therefore, expect the problem of mental diseases to increase as our population grows older.

Except for disabilities connected with military service the discovery, diagnosis and treatment of individuals with mental disorders is the responsibility of the civilian health authorities. The seriousness of the consequences of mental illness is not only reflected in the extent of the problem but also in the economic consequences. Fifty per cent of all the pensions paid by the Veterans' Administration is for psychiatric disorders; and the Veterans' Administration has estimated that the cost to it of maintaining these persons in its hospitals amounts to as much as $40,000 or more per case. In 1942 the total budgets of public psychopathic hospitals alone were over $170,000,000 and ten years from now, at the present rate of increase, their budgets can be expected to exceed $250,000,000 annually. High as they are, these figures do not even represent the total direct cost of hospitalization. Not all mental hospitals are included in these figures and no breakdown is available showing the cost of mental patients in institutions which have both mental and general patients.

The economic losses resulting from reduced earning power of individuals suffering from psychiatric disorders are far greater than these direct costs. Studies have shown that once

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an individual is admitted for the first time to an institution, his earning power is decreased for the rest of his life on the average by sixty per cent.

The testimony at the hearings show how inadequate are the personnel, services, and facilities available to handle the mental health problem at the present time. Mental hospitals provide care principally for the most seriously ill; yet our mental hospitals are today poorly equipped to serve even the limited function of treatment after the illness of patients has become disabling, a time when treatment has the least chance of being effective. Too often these institutions are equipped to render little more than custodial care, thus offering society merely a means of getting rid of these unfortunates for whom it has failed to provide adequate treatment. Though our knowledge of the prevention and cure of mental diseases is limited, even the meager knowledge we do have is not widely available and is, hence, poorly used.

Under existing conditions, however, it is scarcely to be expected that satisfactory standards of care can be maintained in our mental hospitals. Overworked and poorly supervised attendants cannot give proper attention to patients, and physicians burdened with an average of twice the number of patients recommended by the American Psychiatric Association have little opportunity to give adequate treatment, to say nothing of receiving further training in the newer and more effective methods of therapy.

Mental out-patient clinics, conveniently located and offering facilities for early diagnosis and treatment, give every promise of being the most effective means at our disposal for combating mental disease. The very existence of an adequate number of such clinics, associated with regular hospitals and health centers, would help to break down the public prejudices associated with asylums which now prevent many from seeking the help they require. Our present clinic facilities, however, are wholly inadequate both in number and distribution.

Less than twenty per cent of the number of out-patient clinics required for the prevention, early diagnosis and the treatment of mental illness are now available, and these are concentrated largely in cities having more than 150,000 population and are devoted almost exclusively to child care.

Out-patient clinics are also important for the cure and prevention of the mental illness of our veterans. While care of the service-disabled veterans is primarily the job of the Veterans' Administration, it was pointed out at the hearings that the success of the Veterans' Administration in treating its patients depends on the facilities that are available in the various communities. Even for its service-connected cases, the Veterans' Administration is depending on the establishment of out-patient clinics in the various communities with which the Veterans' Administration can contract for the follow-up or pro-hospitalization care of veteran patients. Moreover, it is of little use to give the veteran fine care if the absence of

care for his family lands him in the psychiatric wards of the veterans' hospitals. If his family is emotionally unstable, he is likely to be. And what is the veteran to do prior to the time when hospitalization is required if he is attacked by a mental illness which is non-service-connected?

From a purely economic viewpoint, such out-patient clinics would readily pay for themselves by reducing the amount of hospital care necessitated by mental illness. It has recently been estimated that the cost of maintenance in the average case committed to a mental institution is $7,000 for civilians and $40,000 for service cases. If each such clinic prevented the commitment of only one veteran with a service-connected disability, or five civilians, per year, more than the estimated average cost of operating a clinic (about $32,000 per year) would be saved. This reckoning takes no account of the saving to the community through the reduction of unemployability, relief, or juvenile delinquency and crime. In addition to reducing the number of commitments, these clinics are capable of rendering needed follow-up care for patients discharged from institutions.

In one state, it was estimated a few years back that the state could save close to $600,000 annually if it had enough clinics or community mental hygiene services available to treat mental cases before, not after, they needed commitment, and close to another $300,000 if adequate clinics existed to permit the parole of some of the institutional cases.

Although it has been estimated that for case finding and early diagnosis of psychiatric disorders and treatment of cases not needing hospitalization the Nation should have as a minimum one all-purpose psychiatric out-patient clinic for each 100,000 of the population, with such special clinics as experience may show to be needed in certain areas; the present shortage of psychiatrists makes it impossible to reach this goal in the near future. On the basis of present resources, during the first year the establishment of one clinic for each 500,000 of the population would add about 100 clinics through the nation. It should be noted that these clinics will not only provide pre-hospitalization care and follow-up care for patients discharged from mental institutions; they would also provide the nucleus or key for almost all research and training in the field of psychiatry.

Research in the field of mental illness has up to the present time been utterly inadequate in view of the magnitude of the problem and its serious consequences to our society. It is estimated that not more than $2,500,000 is spent annually on research in psychiatry and related fields, as compared to an expenditure of at least $250,000,000 or 100 times as much for the maintenance of mental institutions.

The history of public health shows that more substantial sums for preventive work must be expended and a greater proportion of the total expenditures for a particular disease must be allocated to research work if we are to make any real progress in this field. All public and private Government

agencies together are spending not more than twenty-five cents per year for research for each estimated case of mental illness, and only one dollar for each known case of total disability because of mental ill health, as compared, for example, with $100 per case of poliomyelitis, a disease which is far less widespread.

The lack of technical personnel constitutes, however, only part of the mental health problem, for increasing the number of trained psychiatrists, even to a considerable extent, can never meet the existing psychiatric problems. The first line of psychiatric defense is the general medical practitioner. Today, the general practitioner is inadequately trained to handle mental illnesses. General practitioners who are well-grounded in psychiatry have estimated that one-half to two-thirds of their patients are suffering in whole or in part from psychiatric difficulties which either cause or aggravate the supposedly organic conditions of which they complain. The family physician's knowledge of his patient and his background places him in a particularly advantageous position to handle the patient's psychiatric maladies. Well-known psychiatrists also, have expressed the opinion that the general practitioner if properly trained, also can deal competently with the majority of mild cases of mental illness, particularly in the early stages where a slight amount of preventive treatment may suffice to stave off an otherwise disabling malady. Given adequate training the general practitioner will be able to recog-

nize and handle the bulk of minor ailments with which the general practitioner's patient may be afflicted.

Psychiatric training today is inadequate in perhaps one-third of our medical schools and it was nonexistent at the time when many of our older physicians received their medical training. Accordingly, a mental health program must call for the encouragement of adequate psychiatric training in medical schools for the improvement and expansion of teaching facilities.

F. National M ental Health - A discussion of the inadequacy of the Nation's mental health facilities and programs.

The problem of the returning veteran suddenly has thrown into bold relief the inadequacy of the nation's mental health facilities. This inadequacy is not the result of war-borne increase in psychiatric disorders alone. For years the campaign for mental health has struggled against immense odds--the geographical isolation of mental hospitals, the slow conversion of asylums into hospitals maintaining advanced modern medicine, the social stigma attached to mental deficiencies or even to minor emotional disturbances, the unwillingness of people to accept mental health as a concomitant of physical health, laws affecting the mentally ill based on criminal procedure, the indifference of medical schools toward training psychiatrists, and the poor financial support limiting research and the training of personnel.

Mental health authorities see as the solution to this

problem an over-all national mental health program, sponsored by the Federal Government but calling on the best private abilities in the country and abroad.

The problem presented by nervous and mental diseases is an enormous one--the most serious medical problem facing our nation. Out of every twenty-two living persons, one will spend part of his life in a mental hospital. Recent studies indicate that one out of every ten persons in the United States is emotionally or mentally maladjusted and needs treatment for some personality disorder. More than half the patients who visit their family doctor for some physical ailment are really suffering from some type of emotional disorder. Nervous and mental disease take a larger toll than do cancer, infantile paralysis, and tuberculosis combined.

We can cut the toll if we have more mental hygiene clinics where parents can come to talk over with trained persons their own problems and the problems of their children. These clinics can sometimes ward off an impending illness by giving prompt treatment and save persons who might otherwise have serious breakdowns. In other cases life is made more bearable and productive.

Every community should have such a center. Yet there are twenty-five states where no psychiatric treatment of any kind can be had. We have only one-fifth of the number of clinics we need. Experts are now at work planning the best methods of putting up clinics throughout the country, but wider support

is needed for such measures if the job is to be done effectively.

Maintaining our public institutions for the care of the mentally ill costs us over $200,000,000 each year. Yet these funds are not enough to maintain minimum standards of physical well-being. Some of our states spend as little as forty cents a day to care for each patient as compared to private institutions which spend upward from eight dollars a day a patient.

The most pathetic cry in the land, perhaps, is that of people who feel they are going under, emotionally, and ask for psychiatric help. They cannot be hospitalized, generally, unless they have pitched over the border into frankly psychotic or legally insane states. Rarely can they afford private psychiatric treatment, which, under present conditions, costs so much that only wealthy people can afford it. Mental clinics, free or charging moderate fees, are rare, and even these usually carry such a load that only superficial treatment can be given.

Ordinarily a person ill in the physical sense, except in acute cases, receives considerable medical attention in the physician's office or at home, and hospitalization is reserved as a last resort. Why should mental disorders be an exception to this practice? Why are many mental cases allowed gradually to develop without any medical attention for mentally ill persons? Why is it necessary for commitment to be sought in order to get medical attention for mentally ill persons? The

majority of first admissions to our State hospitals have never seen a mental specialist until they arrive at the hospital, already seriously ill, with only the prospect of sharing a psychiatrist's time with perhaps 400 other patients. Why neglect the mentally ill until they have progressed to commitment to a hospital with only a fifty-fifty chance of not having to die in a mental institution?

We spend fortunes for hospital care of the end products of mental disturbances but only pittances for prevention. Blindly and foolishly we continue to pay $210,000,000 a year of public funds to maintain our mentally ill in hospitals, but only about $5,000,000 for the support of mental hygiene clinics to prevent their commitment. To reverse the old adage about the forest and the trees, we have not been able to see the trees, represented by our individual early cases, because of the forest of mentally ill in the hospitals.

The need to strengthen and enlarge the facilities and opportunities for professional education and training, and for clinical research, is so large and obvious as to require little elaboration. There is little doubt that the national burden of illness and disability could be greatly reduced by consistent and adequately financed effort toward the acquisition of new medical knowledge and skills and toward more extensive application of what is known.

The necessity for medical research of a clinical nature is attested to by the relatively limited advancement that has

occurred in several major areas of disease control. Medical progress in the control of the chronic diseases, particularly the so-called "degenerative" diseases, and mental diseases, for instance, has not kept pace with the vast improvements in sanitation and in the control of communicable diseases. In fact, medical and public health efforts in the past half century have so effectively been directed at diseases which generally occur in the early years of life, thereby increasing average length of life, that diseases of later life are progressively becoming an increasingly acute problem.

Our mental-disease problem is extensive and costly. Our knowledge of how to prevent and cure these diseases is limited. Even the meager knowledge which we have is not widely available and hence poorly utilized. Facilities both for developing new knowledge and extending its application are deficient. In other words, the problem is vastly complicated by a lack of resources with which to meet it. Psychiatry is a relatively new specialty of medicine. Prior to the development of such scientific psychiatric knowledge as we now have, patients with mental disease were uniformly treated at social outcasts.

Research, however, is our greatest potential weapon. If we merely apply what is now known, we can accomplish a considerable amount; but research has only begun to solve the enigmas of mental disease. A great deal more must be learned about the causes and nature of mental illness. More reliable methods of diagnosis must be devised, and much more effective methods of

prevention and treatment discovered, if we are to make the progress in mental health that we have made in other medical fields.

G. National Mental Health Act

The National Mental Health Act, which became law on July 3, 1946, shows promise of closing some of the gaps in our facilities for treatment of mental disorders. Recognizing the need for more psychiatrists and therapists, the act authorizes the United States Public Health Service to form a National Institute of Mental Health to serve as a center for training and research. The bill also makes provisions for grants-in-aid to public and non-profit institutions for training internes and residents in psychiatry, and makes liberal provisions for fellowships in psychiatry in graduate medical schools.

The bill is not designed to furnish federal funds for this routine care of patients in mental hospitals. Rather, it provides for a program of early diagnosis and prevention in order to reduce the number of patients needing long-term care. To meet this need for an effective program of prevention, grants can be made to the states for the establishment of centers for prevention and diagnosis. A National Advisory Council composed of six leading medical or scientific authorities is to be responsible for reviewing research projects and providing information about mental health. The bill will greatly expand the present advisory services of the United States Public Health Service.

During 1947, one million dollars has been distributed, under provisions of this act, among the states for purposes of research in Mental Health. Part of this money is designated for community clinics like the Judge Baker and Child Habit Clinics of Boston, Massachusetts; the largest amounts go to the training of professional personnel; the remainder is allotted for pure research.

Chapter IV

Summary and conclusions

This study was undertaken to ascertain the medical and mental health needs of the people of the United States and to indicate the adequacy with which they are being met. A great deal more needs to be done to provide adequate medical and mental care. The study shows that beds both general and special are very unevenly distributed. Furthermore governmental and nongovernmental activities in the hospital field are uncoordinated. On a nationwide scale there has not yet been a fulfillment of the desire of the American public and the tradition of the medical profession that medical facilities and services should be available in proportion to needs not in proportion to resources. Only through the use of funds gathered over a wider area, such as a state or nation, can local or regional difficulties be diminished and needed facilities be made available in the poorer sections.

The clinic movement in the United States has advanced without being a part of a broad health program. There has been a failure to organize physicians' service and to place the clinic in an integrated system of preventive services.

The Wagner, Capper and Eliot Bills propose three different types of thought with reference to governmental jurisdiction in the field of health insurance; the Wagner Bill providing for relatively independent state systems, subsidized by the Federal government; the Capper Bill providing for state sys-

tems, with a larger amount of Federal participation and control; and the Eliot Bill establishing a completely Federalized system. None of these bills have been passed by Congress.

On August 13, 1946 the Hill-Burton Hospital Survey and Construction Act became law. This law provides federal grants up to $3,000,000 to states for construction of hospitals and health centers. According to careful estimates made by the United States Public Health Service, facilities are needed for 100,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds. Approximately 2,400 modern structures are needed to serve as headquarters for local health departments.

No pattern can be established at the national level that can practicably be applied to the varying conditions in each community; nor can national regulation deal adequately and fairly in the determination of local need or the application of proper local remedies. It would seem that any legislation directed to this field would be largely concerned with providing financial assistance where need can be demonstrated and with setting up safeguards to determine equable distribution of that assistance.

The subcommittee on Wartime Health and Education felt that there are three necessary methods of approach to the task of providing good medical care for all the people. The first involves education of the people, of the professions, and of the Government. The second is through legislation. The third

is through better organization of medical services. Many experts emphasize that full employment and adequate social security are indispensable to a truly effective health program.

A complete solution of the problem of medical facilities and services to everyone is not immediately possible. Progress must come through adjustment of individual medical needs to existing knowledge and resources. Financial resources are widely dispersed and are controlled by individuals, governments, societies and institutions. Medical resources are found almost entirely within the medical profession. Unified means of utilizing these medical resources places the duty of direction in the hands of the medical profession. The various county and state medical societies, in their effort to meet the demands placed on them by this duty, have undertaken experiments that may be helpful in an attempt to find a more complete solution of the ultimate goal of good medical care for everyone.

Any national health plan in a democracy must consider all needs; draw upon all resources; weigh limitations; accept risks. The vast accomplishments of this Nation in war have taught us that we possess the physical resources, the brains, and the manpower, to attain the purposes of peace. They can be attained through the democratic process, as we have attained every forward step in social welfare through the years of our existence as a nation.

There are four major fields in which facilities for promoting mental health are now operative: remedial work for the

mentally ill; therapeutic prevention; constructive prevention; and research. Extension of census surveys, agencies publicly and privately financed, national promotional bodies, ready co-operation on the part of the community agencies, and an informed public opinion are all necessary if research designed to promote mental health is to be advanced.

It was pointed out that institutional care must be provided for all the feebleminded who cannot care for themselves or make essential adjustments in the community and whose parents cannot provide suitable care for them.

The White House Conference on Child Health and Protection in 1930 recommended that no inflexible statutes should be tolerated. Laws authorizing the establishment of school clinics reaching every public school district throughout the state should be enacted. The formation of special and differentiated classes should be authorized. It is vital to develop a program of education which reaffirms the principle that handicapped children are not peculiarly set apart from other children and that their needs are the common needs of all children, although because of some physical or mental handicap they require a more intensive application of medical care and of social, economic, or vocational education.

It is to be hoped that before many years the public school, through special classes and other pedagogic provisions, will be so organized to deal with mentally deficient children that it will be the largest and most important single agency in developing them for social and economic usefulness and in

preventing social failures.

It is estimated that 8,000,000 people, more than six per cent of the population, are suffering from some form of mental illness. About 125,000 new cases of mental disease are admitted to hospitals each year. The personnel, services, and facilities available to handle the problem at the present time are very inadequate. Mental hospitals provide care principally for the most seriously ill; yet our mental hospitals today are poorly equipped to serve even the limited function of treatment after the illness of patients has become disabling, at a time when treatment has the least chance of being effective. Too often these institutions are equipped to render little more than custodial care, thus offering society merely a means of getting rid of those unfortunates for whom it has failed to provide adequate treatment.

Mental out-patient clinics conveniently located and offering facilities for early diagnosis and treatment, give every promise of being the most effective means at our disposal for combating mental disease. Less than twenty per cent of the number of out-patient clinics required for the prevention, early diagnosis and treatment of mental illness are now available, and these are concentrated largely in cities having more than 150,000 population and devoted almost exclusively to child care.

Research in the field of mental illness has up to the present time been utterly inadequate in view of the magnitude of the problem and its serious consequences to society. It is

estimated that not more than $2,500,000 is spent annually on research in psychiatry, as compared to an expenditure of at least $250,000,000 or 100 times as much for the maintenance of mental institutions.

Mental disease throughout the world at present is an increasing rather than a decreasing social problem. The proportion of the population suffering from mental disease is constantly getting larger, and economic losses due to mental disease are constantly mounting. This situation, however, is not without hope. Much has been learned concerning the causes and nature of the various abnormal mental conditions, and progress is being made in their treatment and prevention. We can take courage from what has been accomplished in the field of physical disease, and we may confidently expect that by multiplying means of research and by diligently disseminating recently acquired knowledge of mental hygiene, the burden of mental disease will be lessened for future generations.

The National Mental Health Act which became law on July 3, 1946 shows promise of closing some of the gaps in our facilities for treatment of mental disorders. The act authorizes the United States Public Health Service to form a National Institute of Mental Health to serve as a center of training and research. The Bill also makes provisions for grants-in-aid to public and non-profit institutions for training internes and residents in psychiatry, and makes liberal provisions for fellowships in psychiatry in graduate medical schools. However

during 1947 only one million dollars has been distributed among the states under the provision of this act for purposes of research in mental health.

The public puts greater pressure on public health institutions than on mental health institutions. We may well look forward to improvement of this situation in the hope that the public will be more aware of the importance of equally good mental health institutions and facilities.

It would be of utmost value if private funds from insurance companies, religious, fraternal, industrial and social organizations would be donated for research in the field of mental health.

The stigma attached to the state mental hospital might be lifted if psychiatric clinics, open to the public, were attached to these hospitals. As it is they are an isolated unit. More and more schools of medicine are giving their students psychiatric orientation. It would be well if each student could spend some part of his training period in a state mental institution.

One of the serious defects of our present organization of the social structure is that the resources of the community are largely concentrated on aiding the deprived or underprivileged stratum of society or on serving the people of wealth who have at their command the means with which to secure any professional aid which they may feel they require. For members of the great middle class there are few opportunities to avail themselves of skilled help in the baffling problems confronting them.

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Approved,

Richard K. Conant

Richard K. Conant, Dean